
September 2012

VA AND DOD HEALTH CARE

Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities

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Why GAO Did This Study

VA and DOD operate two of the nation's largest health care systems at estimated annual costs of about \$53 billion and \$49 billion, respectively, for fiscal year 2013, and have established collaboration sites to deliver care jointly with the aim of improving access, quality, and cost-effectiveness of care. In addition, collaborations could help reduce duplication and overlap between the two health care systems, potentially saving tax dollars and helping VA and DOD provide more efficient and effective services.

A committee report accompanying the Consolidated Appropriations Act, 2012, directed GAO to report on aspects of VA and DOD collaboration. This report examines the extent to which (1) VA and DOD assess effectiveness and efficiencies at collaboration sites; (2) barriers exist that affect collaboration; and (3) VA and DOD identify opportunities for collaboration. GAO conducted site visits to selected VA and DOD collaboration sites; reviewed VA and DOD documents such as sharing agreements; and interviewed VA and DOD officials.

What GAO Recommends

GAO recommends several actions, including that VA and DOD: require collaboration sites to develop performance measures related to access, quality, and costs; address barriers hindering collaboration; and develop a process to more systematically identify new or expanded collaboration opportunities. VA and DOD generally concurred with GAO's recommendations and noted steps they are taking to address them.

View [GAO-12-992](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov, or Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

September 2012

VA AND DOD HEALTH CARE

Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities

What GAO Found

The Department of Veterans Affairs (VA) and Department of Defense (DOD) do not require that all collaboration sites—locations where the two departments share health care resources through hundreds of agreements and projects—develop and use performance measures to assess their effectiveness and efficiency. Officials cited several reasons for this, including not wanting to overburden sites with measures and monitoring requirements. Although VA and DOD require some limited performance information—such as the return on investment for pilot projects—without comprehensive performance measures, they lack information that could help decision makers assess collaboration sites' overall progress in meeting the departments' shared goals of improved health care access, quality, and costs; identify areas for improvement; and make informed decisions. Also, the departments cannot document the overall cost effectiveness of their collaboration efforts. In the absence of required measures for all sites, some have developed their own, but these fragmented efforts do not provide sufficient information about the overall results of collaborations.

The departments face a number of key barriers that hinder collaboration efforts. In particular, GAO identified incompatible policies and practices in four areas:

- **Information technology (IT) systems.** Because VA and DOD collect, store, and process health information in different IT systems, providing access to information needed to best treat patients has proved problematic.
- **Business and administrative processes.** Different billing practices, difficulties capturing patient workload information, and overlapping efforts in credentialing providers and computer security training reduce efficiency.
- **Access to military bases.** Balancing base security needs with veterans' needs to access medical facilities on base creates some difficulties.
- **Medical facility construction.** Misaligned construction planning processes hinder efforts to jointly plan facilities to serve both VA and DOD beneficiaries.

Although VA and DOD officials have taken some steps to address these areas, such as efforts to improve data sharing, without additional department-level actions, barriers will continue to hinder collaboration and lead to inefficiencies.

VA and DOD do not have a fully developed process for systematically identifying all opportunities for new or enhanced collaboration. Instead, the identification of those collaboration opportunities is largely left to local medical facility leadership. Although the departments have a process for jointly identifying a select number of sites with opportunities for new or expanded collaboration, that process does not address all opportunities for collaboration across both health care systems and there is no requirement that sites identified by that process move forward to implement collaboration. Without a fully developed process to systematically identify and select additional collaboration opportunities, the departments may miss opportunities to achieve their shared goals and reduce duplication of services, such as through additional sharing agreements.

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Abbreviations

DOD	Department of Defense
eDR	enhanced Document Management and Referral Management
iEHR	integrated electronic health record
IPO	Interagency Program Office
IT	information technology
JIF	Joint Incentive Fund
JMO	joint market opportunity
VA	Department of Veterans Affairs
VISN	Veterans Integrated Service Network

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United States Government Accountability Office
Washington, DC 20548

September 28, 2012

Congressional Addressees

The Departments of Veterans Affairs (VA) and Defense (DOD) operate two of the nation's largest health care systems, together providing health care to nearly 16 million veterans, servicemembers, military retirees, and other beneficiaries at estimated annual costs of about \$53 billion and \$49 billion, respectively, for fiscal year 2013.¹ Although the two departments have different missions, both provide health care services and have been authorized to exchange health care resources since the 1982 enactment of the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.² Specifically, VA and DOD were authorized by the act to enter into contracts or sharing agreements to improve access to, and the quality and cost-effectiveness of, health care provided by the two departments. Subsequently, the departments have instituted a policy that allows VA and DOD to charge one another at least 10 percent less for clinical services than they would in locations without sharing agreements.³

Since the 1980s, VA and DOD have entered into many types of collaborations to provide health care services—including emergency, specialty, inpatient, and outpatient care—to VA and DOD beneficiaries, reimbursing each other for the services provided. These collaborations vary in scope, ranging from agreements to jointly provide a single type of service to more coordinated “joint ventures,” which encompass multiple health care services and facilities and focus on mutual benefit, shared risk, and joint operations in specific clinical areas. The departments also have collaborated on the joint construction of medical facilities and have

¹DOD's fiscal year 2013 budget request for its Unified Medical budget includes \$32.5 billion for the Defense Health Program, \$8.5 billion for military medical personnel, \$1.0 billion for military construction, and \$6.7 billion set aside for the Medicare-Eligible Retiree Health Care Fund. The total excludes overseas contingency operations funds.

²See 38 U.S.C. § 8111. The Department of Veterans Affairs was previously known as the Veterans Administration.

³In a memorandum of understanding effective in fiscal year 2003, the departments established a policy for reimbursement for health care services they share, which allows the collaborating facilities to use a 10 percent discount from the standard allowable charge for clinical services and certain specialty services.

jointly funded pilot projects related to VA and DOD collaboration activities. The Secretaries of Veterans Affairs and Defense both have expressed their commitment to greater collaboration between the two departments on several issues of common interest, including better health care access for servicemembers, veterans, and other VA and DOD beneficiaries, and to most effectively use resources.

VA and DOD's current and future efforts to collaborate on the delivery of health care services have the potential to yield significant cost savings and other benefits, such as a reduction in the duplication of health care services.⁴ We have previously reported that reducing or eliminating government-wide duplication could potentially save billions of tax dollars annually and help agencies provide more efficient and effective services.⁵ This is especially important for VA and DOD given that the departments have experienced and continue to experience rising health care costs. Specifically, both VA's and DOD's fiscal year 2013 budget requests reflect anticipated medical care expenses that are more than double their 2001 costs. Duplication and overlap can occur for a variety of reasons, including that agencies lack information on the effectiveness of programs that could help decision makers prioritize resources among programs. We have previously identified the need for improvement in the evaluation of current and potential VA/DOD collaboration efforts, as well as challenges VA and DOD face in their efforts to share health care resources.⁶ Efforts leading to a reduction in duplication and overlap can help inform decision makers as they address escalating fiscal pressures currently facing the federal government.

A committee report accompanying the Consolidated Appropriations Act, 2012, directed GAO to report on aspects of VA and DOD collaboration.⁷ In this report, we examine the extent to which

⁴Collaboration can be broadly defined as any joint activity that is intended to produce more public value than could be produced when the organizations act alone.

⁵GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-635T](#) (Washington, D.C.: May 25, 2011).

⁶GAO, *VA Health Care: Additional Efforts to Better Assess Joint Ventures Needed*, [GAO-08-399](#) (Washington, D.C.: Mar. 28, 2008) and *VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed*, [GAO-11-570](#) (Washington, D.C.: July 19, 2011).

⁷H.R. Rep. No. 112-94, at 52 (2011).

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1. VA and DOD assess effectiveness and efficiency for locations where they collaborate to deliver joint health care services;
 2. Barriers exist that affect VA and DOD collaboration to deliver joint health care services, and whether the departments have developed strategies to address these barriers; and
 3. VA and DOD identify opportunities for collaboration to deliver joint health care services.

To address these three objectives, we conducted site visits, attended the 2011 VA and DOD joint venture conference, reviewed documentation, conducted interviews with VA and DOD officials, and reviewed relevant GAO reports.⁸

- We conducted site visits to 2 of the 10 joint ventures—Honolulu, Hawaii, and Biloxi, Mississippi—where we met with officials from VA and DOD to discuss and observe their collaboration efforts.⁹ We also reviewed and analyzed documents from the locations we visited, such as sharing agreements, performance measures, and any estimates local officials had calculated of cost savings related to their collaboration. As part of the site visit to Biloxi, we also met with leaders from nearby military treatment facilities that collaborate with that VA facility.¹⁰ In addition, we visited Ft. Benning in Columbus, Georgia and interviewed VA and DOD officials to learn about plans for collaboration in that location.

⁸Since 2004, VA and DOD have convened an annual conference to highlight the progress and accomplishments of joint ventures, as well as provide a forum for discussing common barriers to success, lessons learned, and best practices. The 2011 conference was held in Charleston, South Carolina, in October 2011.

⁹We selected these two joint venture locations because they represented a range of collaboration efforts, as well as collaboration involving all three military services—the Army, the Navy, and the Air Force. The VA and DOD partners at the Honolulu joint venture are Tripler Army Medical Center and the VA Pacific Islands Health Care System, and at the Biloxi joint venture are Keesler Medical Center/81st Medical Group at Keesler Air Force Base and the VA Gulf Coast Veterans Health Care System. The remaining eight joint ventures are located in Albuquerque, New Mexico; Anchorage, Alaska; Charleston, South Carolina; El Paso, Texas; Fairfield, California; Key West, Florida; Las Vegas, Nevada; and North Chicago, Illinois.

¹⁰We met with leaders from Naval Hospital Pensacola, the 96th Medical Group at Eglin Air Force Base, and the 325th Medical Group at Tyndall Air Force Base in Florida about their collaboration with the VA Gulf Coast Veterans Health Care System.

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- We attended the annual VA and DOD joint venture conference in October 2011, where we obtained information during detailed presentations given by all 10 joint ventures regarding their collaboration efforts, the problems they face, and plans for future sharing opportunities; heard presentations by VA and DOD department-level officials; and toured the Charleston, South Carolina, joint venture site.¹¹ This information led to the identification of key barriers affecting VA and DOD collaboration.¹²
 - We reviewed and analyzed relevant VA and DOD documentation, including the VA/DOD Joint Strategic Plan for Fiscal Years 2011-2013 (Joint Strategic Plan) and departmental and joint VA/DOD guidance regarding collaboration options, approaches used to identify opportunities for collaboration, and performance measures required of collaborating VA and DOD partners.
 - We interviewed VA and DOD department-level officials, including officials from both departments' collaboration offices, construction planning offices, and the Interagency Program Office responsible for joint VA/DOD information technology (IT) initiatives. We also interviewed officials from the three military services—the Army, the Navy, and the Air Force—who are involved with VA/DOD collaboration efforts,¹³ as well as officials from some of VA's 21 regional Veterans Integrated Service Networks (VISN).¹⁴
 - We reviewed our past work, including reports on best practices for federal agency collaboration efforts, VA and DOD's efforts to share medical information between the two departments, the status of VA and DOD's efforts to establish an integrated federal health care center

¹¹The partners at the Charleston joint venture are: Ralph H. Johnson Veterans Affairs Medical Center; Naval Health Clinic Charleston; the Air Force's 628th Medical Group; and the Naval Hospital Beaufort.

¹²We defined key barriers as those issues that were factors across multiple collaboration sites or posed significant difficulties at one or more sites.

¹³The Navy is responsible for providing health care to members of the Marine Corps and their beneficiaries.

¹⁴VA's health care system is organized into 21 VISNs charged with the day-to-day management of the medical facilities within their network. VA's Central Office is responsible for monitoring and overseeing VISN and medical center operations.

in North Chicago, Illinois, and best practices for establishing evaluation criteria to assess federal programs.¹⁵

We conducted this performance audit from November 2011 through September 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA and DOD have distinct missions and health care systems to provide services to their respective beneficiaries. VA and DOD provide some similar services in locations where they have facilities near each other, and have established an organizational structure to plan and carry out a variety of joint projects. In addition, there are several options for VA and DOD collaboration to deliver health care services jointly.

VA and DOD Health Care Systems

In addition to having separate missions—VA's to serve America's veterans, and DOD's to provide the military forces needed to deter war and protect the country's security—the departments have distinct health care systems through which they provide a range of health care services to their respective beneficiaries.¹⁶ In addition, each has a framework that outlines its vision and goals for the care and services they deliver.

¹⁵See GAO, *VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed*, GAO-11-570 (Washington, D.C.: July 19, 2011); *VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Demonstration Evaluation Plan Lacking*, GAO-12-669 (Washington, D.C.: June 26, 2012); *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005); *Limitations in DOD's Evaluation Plan for EEO Complaint Pilot Program Hinder Determination of Pilot Results*, GAO-08-387R (Washington, D.C.: Feb. 22, 2008); *Tax Administration: IRS Needs to Strengthen Its Approach for Evaluating the SRFMI Data-Sharing Pilot Program*, GAO-09-45 (Washington, D.C.: Nov. 7, 2008).

¹⁶VA beneficiaries include veterans of military service and certain dependents and survivors. DOD beneficiaries include active duty servicemembers and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and military retirees and their dependents and survivors.

VA's health care system includes a network of approximately 150 hospitals, 130 nursing homes, 800 community-based outpatient clinics, as well as other facilities to provide care to veterans. VA also purchases care from outside its network as needed to provide services for its beneficiaries. VA estimates it will serve 6.3 million patients in the VA health care system in fiscal year 2013 and has requested \$52.7 billion for its health care services for that year. VA's "I CARE" framework broadly outlines the department's goals for delivering health care services and in particular, cites the importance of access to, and the quality and cost of, VA health care.

DOD's health care system—known as the Military Health System—serves about 9.6 million beneficiaries. According to a 2011 Congressional Budget Office report, DOD's health care costs are projected to reach \$59 billion by 2016 and nearly \$92 billion by 2030.¹⁷ DOD provides care through its system of approximately 60 military treatment facilities that provide diagnostic, therapeutic, and inpatient care; hundreds of clinics; and by purchasing care from a network of private-sector civilian providers.¹⁸ Each of the military services, under its respective surgeon general, is responsible for managing its own military treatment facilities. The Military Health System's "Quadruple Aim" outlines the department's vision for delivering health care services and—similar to VA's I CARE framework—emphasizes health care access, quality, and costs.

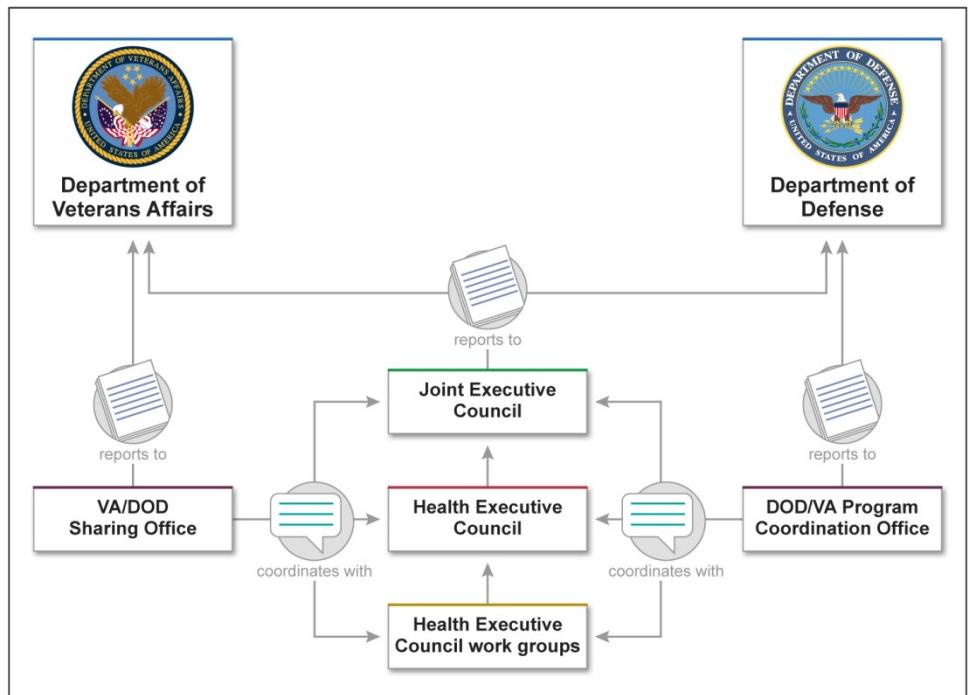
VA and DOD Organization for Collaboration and Joint Strategic Planning

VA and DOD have an organizational structure in place to plan and carry out a variety of joint projects and collaboration efforts. (See fig. 1.)

¹⁷Congressional Budget Office, Long-Term Implications of the 2012 Future Years Defense Program, Pub. No. 4281 (June 2011).

¹⁸Under DOD's TRICARE program, beneficiaries can obtain care either from providers at military treatment facilities or from civilian providers.

Figure 1: Organizational Components Related to VA/DOD Collaboration



Source: GAO.

Specifically, the Joint Executive Council—co-chaired by the Deputy Secretary of VA and the Under Secretary of Defense for Personnel and Readiness—is made up of senior VA and DOD officials and provides broad strategic direction for interagency collaboration between the two departments. The Health Executive Council, a subcouncil of the Joint Executive Council, provides oversight for the specific cooperative efforts of each department's health care organizations. The Health Executive Council has organized itself into a number of work groups to carry out its responsibilities. For example, Health Executive Council work groups focus on issues such as financial management, pharmacy, and IT, among several others. In addition to this interagency structure, there are department-level coordination offices—VA's VA/DOD Sharing Office and DOD's DOD/VA Program Coordination Office. These offices coordinate with, but do not have a direct reporting relationship to the Joint Executive Council and the Health Executive Council.

The Joint Executive Council and the Health Executive Council also provide oversight to the 10 joint ventures by providing some level of

direction and support for their activities. (See fig. 2 for the locations of the current joint ventures.)

Figure 2: Location of VA/DOD Joint Ventures, as of August 2012



Source: GAO.

Further, the Joint Executive Council has developed the Joint Strategic Plan, which conveys the direction and goals for collaboration efforts for the two departments. The plan outlines the departments' primary goals, which include developing a health care system that delivers quality, access, satisfaction, and value, consistently across the departments, and establishes a national model for effective and efficient delivery of benefits and services through collaboration. The plan also outlines specific initiatives designed to ensure leadership, commitment, and accountability for VA and DOD's collaboration activities.

Options for VA and DOD Collaboration to Deliver Health Care Services

There are three primary options for collaboration that VA and DOD may pursue to jointly deliver health care services: sharing agreements, joint ventures, and Joint Incentive Fund (JIF) projects (see table 1). Collaboration sites can pursue a combination of these sharing options.

For example, a site with sharing agreements in place can pursue joint venture status or JIF project funding. In addition to these collaboration options, the departments are required by law to consult with each other regarding certain potential joint construction projects.¹⁹ Department-level officials from VA and DOD identify opportunities for joint construction and coordinate through their respective budgeting and construction planning processes.

Table 1: Key Features and Prevalence of VA/DOD Collaboration Options as of June 2012

Collaboration option	Key features	Prevalence
Sharing agreement	<ul style="list-style-type: none"> • Ranges in complexity and scope from sharing a single service to agreements that govern the sharing of multiple services • Allows partners to reimburse each other for services or procedures provided to beneficiaries at negotiated rates, at a cost savings of at least 10 percent • Local partners identify opportunities • Veterans Integrated Service Networks (VISN),^a DOD counterparts, and department-level staff review agreement and determine whether to implement 	Nearly 200 active sharing agreements in place
Joint venture	<ul style="list-style-type: none"> • Shares multiple health care services and sometimes facilities • Has increased flexibility to determine reimbursement rates than with sharing agreements alone • Local partners typically decide whether to pursue the option and VA and DOD department-level staff make the formal designation 	10 joint ventures
Joint Incentive Fund (JIF) project	<ul style="list-style-type: none"> • Provides funding for pilot projects that may result in new sharing agreements • VA and DOD jointly issue a call for JIF project proposals at least once per year • Locations with sharing agreements in place, joint ventures, and other sites may apply for funding • Typically, local VA and DOD partners determine whether to apply 	Since Congress established the JIF in 2003, ^b 130 projects funded, totaling \$418 million ^c

Source: GAO.

^aVA's health care system is organized into 21 VISNs charged with the day-to-day management of the medical facilities within their network.

^bBob Stump National Defense Authorization Act for Fiscal Year 2003, Pub. L. No. 107-314, § 721(a)(1), 116 Stat. 2458, 2591 (2002) (codified as amended at 38 U.S.C. § 8111(d)).

^cTotals include projects funded from 2004 through 2012.

¹⁹Pub. L. No. 108-375, div. B, title XXVIII, § 2811, 118 Stat. 1811, 2128-29 (2004).

VA and DOD Do Not Require Participants in All Types of Collaboration to Develop Performance Measures to Assess Their Effectiveness and Efficiency

We have reported extensively on the importance of developing and using performance measures for effective management and strategic planning, as well as for measuring the achievement of projected cost savings, and other performance goals.²⁰ Furthermore, we have noted that such performance measurement information can assist decision makers in assessing progress and identifying areas for improvement. In addition, the VA and DOD health care collaboration statute,²¹ as well as VA and DOD's own health care goals, all highlight access, quality, and costs as important considerations in the delivery of health care. Finally, VA and DOD department-level officials said it is important to consider costs as a part of both departments' responsibilities to ensure their collaboration efforts are financially sound and improve care.

Performance measures are important to show the extent of progress made in improving access and quality of care, in addition to cost savings achieved, if any, from collaborations. For example, although VA and DOD department-level officials believe that some savings occur when collaboration sites adopt sharing agreements in which partners pay each other less for care than they would otherwise pay community providers, the overall savings are unclear because sites are not required to develop performance measures to assess the extent of their savings. The importance of performance measures regarding costs is highlighted by our prior work on the consolidation and integration of federal facilities—in particular, how such activities can result in unexpected costs that may affect overall results. For example, the North Chicago Federal Health Care Center joint venture experienced unanticipated costs associated with its integration of VA and DOD services, such as hiring the equivalent of 23 full-time staff to manually perform work that was originally expected to be automated. The impact of these additional costs on that integration overall, however, is unknown, because VA and DOD have not established cost-related performance measures.²² Without performance measures in

²⁰See GAO-06-15, GAO-12-669, GAO, VA and DOD Health Care: Opportunities to Maximize Resource Sharing Remain, GAO-06-315 (Washington, D.C.: Mar. 20, 2006), and VA Health Care: Additional Efforts to Better Assess Joint Ventures Needed, GAO-08-399 (Washington, D.C.: Mar. 28, 2008).

²¹See 38 U.S.C. § 8111, which cites improving access, quality, and cost effectiveness as health care collaboration goals.

²²GAO-12-669. Similarly, some of the integration and closures that occurred as a result of the 2005 Military Base Realignment and Closures round ultimately resulted in unexpected cost increases that affected the amount of savings DOD was able to achieve.

place to assess VA and DOD's collaboration efforts, the overall value of these efforts is unclear.

According to VA and DOD department-level officials, the departments do not require that all collaboration sites develop and use performance measures to assess the collaborations' effectiveness and efficiency, in particular to measure their progress in meeting the departments' shared goals of improved health care access, quality, and costs. Officials from both departments cited several reasons why VA and DOD do not require all collaboration sites to develop and use performance measures related to the departments' shared goals. In particular, VA officials told us they do not want to overburden sites with performance measures and monitoring requirements, which they said may discourage future collaborations. VA officials also told us that department-level VA and DOD collaboration offices do not have direct control over medical facilities and are not required to provide oversight or monitoring of performance. Finally, DOD officials said that because each collaboration is unique, performance measures appropriate for one location might not be appropriate for another location.

Although VA and DOD do not require all collaboration sites to develop and use performance measures, the departments do require some limited performance information for certain collaboration options. For example, to receive JIF project funding, sites must estimate the return on investment and propose performance measures related to that estimate and other projected benefits, such as improved access or quality of care. Sites that receive such funding must then periodically use and report on those performance measures during and at the conclusion of the project. In addition, beginning in fiscal year 2013, joint ventures and other selected collaboration sites will be required to report on performance measures to indicate areas where sites have achieved at least a 5 percent reduction in costs or other improvements in efficiency that result from health care collaborations. VA officials told us these measures are not meant to represent overall savings achieved as a result of collaborating, but rather savings from specific, self-selected areas the collaboration sites choose to measure. Although these efforts represent initial steps toward better understanding of the performance and progress of collaboration sites, officials acknowledged that more work remains to be done. VA and DOD officials told us that both departments are working to develop criteria to determine the success of the 10 joint ventures, which they anticipate will be based on the departments' shared goals. As of July 2012, VA department-level officials told us that a set of proposed criteria were still being reviewed internally. They noted that the time frame for

implementing those criteria would still need to be determined, in part because the departments would need to resolve data collection and analysis issues—such as ensuring that collaboration partners had access to reliable and timely information—before any resulting measures could be developed and used to assess sites' progress.

In the absence of a department-level requirement for performance measures for all collaboration sites, some sites we reviewed have developed their own performance measures. Although this information may assist local medical facility leaders to understand the progress and areas for improvement at their sites, the fragmented nature of these efforts does not provide department-level decision makers with information about overall performance or results of VA and DOD collaborations. For example:

- Officials from the Biloxi VA and one of their DOD collaboration partners, Naval Hospital Pensacola,²³ told us that their established discounts for the inpatient services that DOD provides to VA patients through a sharing agreement—the standard 10 percent discount from fiscal years 2009 through 2011, changed to a larger 25 percent discount beginning in June 2012—had resulted in a reported cumulative savings of about \$200,000 for VA since fiscal year 2009, as of July 2012.²⁴
- Honolulu joint venture officials reported that they assess efficiency by tracking the amount of time it takes to schedule appointments for patients who were referred to them by their collaboration partner. Additionally, they measure quality of care using measures derived from patient feedback information. Officials told us that by assessing these measures they are able to identify trends and help ensure that patients are accessing health care.

²³The Gulf Coast Veterans Health Care System located in Biloxi collaborates with the Naval Hospital Pensacola separately from its joint venture with Keesler Air Force Base.

²⁴This figure was self-reported by the VA and DOD partners at this collaboration site. We did not complete a data reliability assessment because these data are being used for illustrative purpose only.

VA and DOD Face Several Significant Barriers That Hinder Collaboration, Despite Taking Some Actions to Address Those Barriers

VA and DOD face a number of significant barriers that hinder their collaboration efforts. We have previously reported that federal agencies can facilitate and enhance their collaboration efforts by establishing compatible policies, procedures, and other ways of operating across boundaries.²⁵ Some problems VA and DOD face are inherent to the differing missions of the two departments.²⁶ However, we also identified several important areas where VA and DOD's lack of compatible policies and practices at the department level and at local collaboration sites hinders collaboration efforts. These incompatible policies and practices fall into four areas: (1) IT systems' ability to share health information, (2) business and administrative processes in place at current collaboration sites, (3) procedures for veterans to access medical facilities on military bases, and (4) joint VA and DOD planning for construction of medical facilities. Although VA and DOD officials at the department and local levels have taken some steps to address issues in these areas, significant barriers remain. Without additional department-level actions to address incompatible policies and practices, those barriers will continue to hinder collaboration efforts and lead to inefficiencies at the local level.

IT Systems' Ability to Share Health Information

As we have reported for over a decade, VA and DOD lack IT systems that permit the electronic exchange of comprehensive patient health information, a significant barrier in their collaboration efforts.²⁷ Access to comprehensive health information is important to providing optimal care to patients who receive health care services from both VA and DOD. However, because VA and DOD collect, store, and process health

²⁵ GAO-06-15.

²⁶ For example, one of the primary missions of DOD medical personnel is to provide medical support for military operations, requiring them to deploy to other locations. This can lead to vacancies at some facilities when military operations occur and other medical personnel are not available to take the place of those who deploy. In addition, leadership at military treatment facilities frequently changes due to periodic personnel reassignment to different duty stations.

²⁷ See, for example, GAO, *Electronic Health Records: DOD and VA Efforts to Achieve Full Interoperability Are Ongoing; Program Office Management Needs Improvement*, GAO-09-775 (Washington, D.C.: July 28, 2009); *Electronic Health Records: DOD and VA Interoperability Efforts Are Ongoing; Program Office Needs to Implement Recommended Improvements*, GAO-10-332 (Washington, D.C.: Jan. 28, 2010); and *Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs*, GAO-11-265 (Washington, D.C.: Feb. 2, 2011).

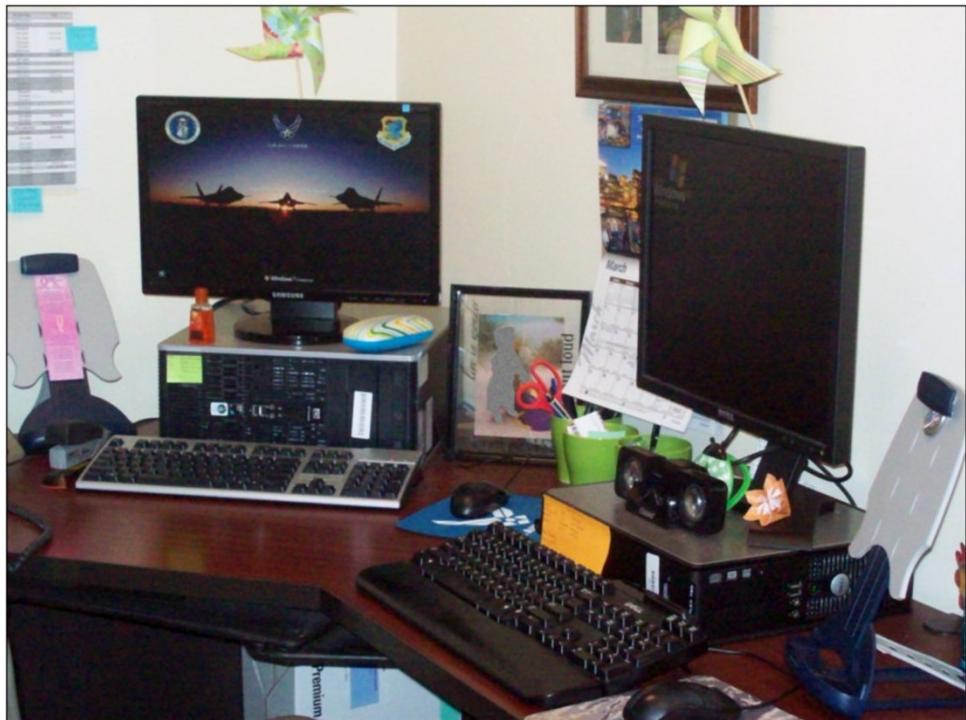
information in different IT systems, providing access to the information needed to best treat those patients has proved problematic.

At collaboration sites, the departments' IT barriers hinder ongoing efforts in many ways. As we have previously reported, a health care provider who lacks access to comprehensive health information about a patient may be challenged to make the most informed treatment decisions, potentially putting the patient's health at risk. The provider also might unknowingly order diagnostic tests that have already been performed, leading to added health care costs. In addition, providers' inability to use their own facility's IT system to easily view the health care records of their collaboration partner's patients can lead to costly inefficiencies. For example, the North Chicago Federal Health Care Center joint venture hired five full-time pharmacists specifically to conduct manual checks of patient records to reconcile allergy information and identify possible interactions between drugs prescribed by providers in both VA and DOD systems. Similarly, Biloxi joint venture officials reported having to rely on inefficient and time-consuming approaches to share information, including manually copying or transferring medical information such as diagnostic images between VA's and DOD's IT systems, or faxing information to their collaboration partner, where it must be entered into the partner's IT system.

Collaboration sites have taken steps to facilitate information sharing, but officials noted that those efforts had limitations and that IT barriers remained. For example, Honolulu joint venture officials developed an IT tool—called “Janus”—that allows providers to view their patients' VA and DOD health care records on a single screen. Officials said this tool has helped providers treating shared patients in a number of ways, providing clinical benefits and allowing providers to work more efficiently. Officials said, for example, that Janus gives providers a more efficient way to view and share diagnostic images taken by collaboration partners and to compare clinical information in both partners' systems, such as patients' medication allergies and laboratory results. However, they noted that it is a “read only” tool that doesn't allow providers to enter data into the other department's IT system; as a result, there are some inefficiencies when providers must take time to separately perform data entry steps outside of their Janus IT tool. At the Biloxi joint venture, staff in some clinical areas use side-by-side dual computers: one to access VA health care records and another to access DOD health care records. (See fig. 3.) Biloxi officials reported that although this approach helps, it is time-consuming and costly, and does not allow staff to share information as efficiently as they would like; for example, there are costs to set up the dual computers

and it takes providers extra time to access both IT systems to review information and share information with their collaboration partners. Biloxi officials also are working with VA and DOD at the department level to test a way of electronically sharing diagnostic images between facilities.

Figure 3: Example of the Side-by-Side Dual Computers Used by Staff at the Joint Venture in Biloxi, Mississippi, to Access VA and DOD Computer Systems



Source: GAO.

At the department level, VA and DOD have worked for many years to improve the ability of their IT systems to share medical information, and have spent millions of dollars on those efforts, but those efforts have not yet led to a comprehensive solution. As we have reported, VA and DOD have increased their ability to electronically share information through a

patchwork of initiatives.²⁸ In April 2009, the President announced that the departments would define and build the Virtual Lifetime Electronic Record to streamline the transition of electronic medical, benefits, and administrative information between the departments.²⁹ Over the past few years, the departments also began working to develop IT capabilities to facilitate information sharing at the North Chicago Federal Health Care Center joint venture that were intended to be “exportable” for use at other VA and DOD collaboration sites. However, those efforts have been delayed, in some cases indefinitely, resulting in costly and inefficient workarounds.³⁰

Most recently, the departments began work on a new common integrated electronic health record (iEHR) that both VA and DOD would use for their beneficiaries. In March 2011, the Secretaries of VA and Defense committed the two departments to developing this new health record and in May 2012 announced their goal of implementing it across the departments by 2017. Officials from the joint DOD/VA Interagency Program Office (IPO),³¹ which is leading the iEHR effort, told us they have substantial financial resources for the iEHR effort, reporting funding of

²⁸For example, the Federal Health Information Exchange, begun in 2001 and completed in 2004, allows DOD to electronically transfer servicemembers’ health information to VA when they leave active duty. In addition, the departments’ Bidirectional Health Information Exchange was established in 2004 to allow clinicians in both departments to view limited health information on patients who receive care from both departments. Also, the Clinical Data Repository/Health Data Repository interface, implemented in 2006, linked the departments’ separate repositories of standardized data to enable a two-way exchange of computable outpatient pharmacy and medication allergy information. See [GAO-11-265](#).

²⁹The Virtual Lifetime Electronic Record initiative is intended to enable access to all electronic records for servicemembers as they transition from military to veteran status, and to enable DOD, VA, and the private sector to share medical, benefits, and administrative information to support servicemembers as they make that transition.

³⁰The agreement that established the North Chicago Federal Health Care Center stated that the IT capabilities developed for that location would be exportable to other collaboration sites. See [GAO-11-570](#).

³¹In January 2009, the departments established the IPO under the Joint Executive Council to act as a single point of accountability for DOD’s and VA’s joint efforts to develop and implement electronic health record systems or capabilities to enable full interoperability of the departments’ health care information, in accordance with the National Defense Authorization Act for Fiscal Year 2008. The IPO was initially responsible for integrating DOD’s and VA’s program management plans and activities for their joint health IT initiatives. However, under its new charter as of October 2011, the IPO has added responsibilities. For example, it now has joint authorization to lead, oversee, and manage all interagency activities related to iEHR as well as other joint IT efforts.

nearly \$550 million across both VA and DOD for iEHR in fiscal year 2012 alone.³² They also said they have made some key decisions about the project. For example, IPO officials plan to begin work at the Honolulu joint venture in September 2012 on IT tools that would be part of the larger iEHR effort, and test initial elements of iEHR at two pilot sites in 2014.

However, the implementation time frame for the new iEHR effort is uncertain. IPO officials told us in April 2012 that they planned to implement elements of iEHR in a phased approach over time, but that full implementation may not occur for at least 4 to 6 years, and that this estimated time frame was both optimistic and uncertain. They said the IPO office was not yet fully staffed, nor did they have final plans for how iEHR would be developed and implemented given that many decisions had yet to be made. For example, they had not yet determined what clinical applications iEHR would include, the time frame for implementing different elements of iEHR across all VA and DOD sites, or the order in which they would implement iEHR at collaboration sites. IPO officials noted that once they complete their work at the iEHR pilot sites they will have a better sense of how the project would proceed. They added that they might select a limited number of other sites to use elements of iEHR as part of their early work on the project; they noted that although they had not yet developed criteria for selecting those additional sites, the joint venture sites would be among those considered.

Overall, given the uncertainty about when and how iEHR will be implemented, it is not clear when collaboration sites could expect to see benefits from this new effort. Although local officials have expressed interest in obtaining IT tools from the departments in the short term to help address their IT barriers, IPO officials said their focus is on developing iEHR rather than implementing separate IT tools at individual facilities. In their view, separate interim efforts to improve the interoperability of facilities' existing health IT systems would take time and resources away from the larger effort to replace those existing systems with iEHR, and it might only be beneficial to invest in local IT efforts that inform the IPO's iEHR work. Until collaboration sites receive IT support from the departments, they will continue to face IT barriers. In addition, sites will continue to rely—and expend resources on—their own solutions

³²According to IPO officials, the iEHR effort has received about \$900 million in funding from its inception through fiscal year 2012; in addition, the President's budget for fiscal year 2013 requested \$500 million in funding for iEHR.

to address those barriers. Without information from the departments regarding the plans for iEHR—specifically, the time frame for when joint ventures and other collaboration sites might begin to have iEHR solutions implemented—local officials will not know when they could begin to see changes due to this new effort and be able to plan accordingly.

**Collaboration Sites’
Business and
Administrative Processes**

VA and DOD collaboration sites face a number of barriers with business and administrative processes that hinder collaboration and are important to their daily operations: reimbursement, capturing information on care provided to patients, credentialing of providers, and computer security training.

Reimbursement for services provided to patients. Aspects of the reimbursement process—such as assigning diagnostic and procedure codes to episodes of care (coding), and authorizing and paying for services—can pose problems, particularly when VA and DOD practices differ. These problems can result in inefficient workarounds at the local level, and difficulties such as backlogs of unpaid bills. Honolulu joint venture officials shared several examples of reimbursement-related difficulties including that the collaboration partners do not use the same coding and billing standards, which can lead to discrepancies that can be difficult to quickly resolve. Staff at DOD’s Tripler Army Medical Center code and bill care provided to veterans based on Military Health System standards, while VA staff reviewing those bills apply VA’s standards,³³ which can lead to difficulties reconciling the two approaches. Honolulu officials said that differences in how VA and DOD treat same-day surgeries, for example—VA considers them outpatient services while DOD considers them inpatient services—lead to the need to manually handle those bills, which takes time.

Honolulu VA and DOD officials agreed that reimbursement difficulties have had a substantial impact on their collaboration efforts, including on their finances. A January 2012 Army review of billing issues at this collaboration site found that there was more than \$20 million in bills from Tripler unpaid by VA for fiscal years 2009 through 2011, which included

³³Both VA and DOD use common health care coding methods when recording information about patient care, but the departments have their own guidance for using those codes and sometimes apply them differently. The codes they use include those that indicate types of medical procedures and diagnoses.

bills that had not yet been processed or had been denied by VA. A July 2011 VA coding audit of bills submitted by Tripler Army Medical Center stated that, as compared to VA's coding standards, DOD's coding was accurate for about 80 percent of the codes used in the sample of bills reviewed. The audit made recommendations to reduce the number of bills needing manual review and expedite VA's payment of bills submitted by Tripler.³⁴ However, Honolulu VA and DOD officials did not always agree with each other on the specific extent or the causes of their reimbursement difficulties.

Biloxi officials also shared examples of reimbursement issues. They noted that differences in VA and DOD coding practices temporarily led to delays in VA paying bills for care provided at Keesler Air Force Base, because some VA and Air Force staff involved with billing and paying for care were not initially familiar with the other collaboration partner's reimbursement practices. In addition, they sometimes have needed to negotiate solutions when VA and DOD's reimbursement practices differ. For example, they had to agree on a reimbursement rate that would apply when Keesler billed VA for certain ambulatory procedures in a way that followed DOD guidance but was new to VA staff.

Honolulu and Biloxi officials have taken some steps to address problems with reimbursement, though difficulties remain. Honolulu officials said implementing an IT tool called "eDR"³⁵ has improved several aspects of their business processes and that bills are now submitted in a faster automated way rather than through the time-consuming manual method

³⁴Honolulu VA officials requested the audit to compare how DOD had coded the care to how VA would have coded the care, with the goal of identifying ways to improve the reimbursement process. The report noted that the audit was based on available documentation about patient care and that a lack of complete documentation about that care may have contributed to some of DOD's codes being determined to be inaccurate. In August 2012, Army officials noted that the Army had recently completed a review of the VA audit and identified areas where they disagreed with VA's analysis and findings. They said that at that time, VA and DOD officials were still in the process of responding to the issues raised by VA's audit and Army's review of it.

³⁵The Honolulu joint venture's eDR IT tool (also known as the "enhanced Document Management and Referral Management" tool) is intended to improve business processes by facilitating the tracking and management of referrals and appointments, streamlining billing and payment, and allowing for data analysis, among other things. An earlier version of this tool was initially implemented in 2007 with an emphasis on document and referral management, but was enhanced in 2009 to include new components in areas such as billing.

previously used. Biloxi officials created the Joint Venture Business Office to help standardize and streamline their collaboration site's business processes.³⁶ Officials reported that this office facilitates communication about issues such as coding and billing and helps resolve any difficulties that arise.

At the department level, VA and DOD officials said VA and DOD have taken some steps to address reimbursement issues, but that sites will still need to find ways to bridge VA and DOD's differences. VA and DOD department-level officials have worked with Honolulu officials to address their difficulties. For example, a group of VA, Army, and other DOD officials began meeting in September 2011 to address coding issues at the Honolulu joint venture; as of June 2012 their work was still ongoing.³⁷ In addition, the departments supported the eDR effort at the Honolulu joint venture by providing more than \$3 million through JIF project funding. Also, VA officials told us that VA has been working since 2009 to implement the Intra-Governmental Payment and Collection System—a federal government effort to provide a standardized interagency fund transfer mechanism for federal agencies—which should help streamline how VA receives and pays bills from DOD, although it would not specifically address coding. Officials noted, however, that work on this system has been halted or delayed several times, due in part to a lack of funding; as of June 2012 VA officials were discussing when and how to proceed but no final decisions had been made. Honolulu VA officials said that this system would help improve their reimbursement process.

Capturing patient workload information. Collaboration sites sometimes have difficulty capturing patient workload information—the type and amount of care provided—which can hinder their collaboration efforts. Biloxi and Honolulu officials said the lack of workload information can be a barrier to collaboration, partly because officials use that information to

³⁶The Joint Venture Business Office includes 16 staff positions—12 VA positions and 4 Air Force positions—to assist with functions such as authorizing episodes of care, coding, billing, paying bills, and analyzing data about services provided through the joint venture. These staff are expected to improve business operations by, for example, facilitating more accurate coding and billing, faster and more accurate bill payment, and faster authorizations of services.

³⁷DOD officials told us that while some coding difficulties occur at collaboration sites other than at the Honolulu joint venture, the extent of the problem in Honolulu is unique and is in part due to the large volume of care that the Army provides to VA at that location.

evaluate and to justify the resources needed for their collaboration efforts. These officials also noted that workload information can affect facilities' future funding. For example, leaders may be reluctant to support new JIF project funding for additional providers if a collaboration site's current providers seem underutilized due to the lack of workload information.

Among the collaboration sites' difficulties collecting workload information, Biloxi VA officials said that, until recently, they were unable to capture workload information when Biloxi VA surgeons treated veterans at one of their DOD collaboration partners—Naval Hospital Pensacola—because that information was not captured through the billing process or in VA's IT systems. DOD has faced similar problems when its providers care for patients at the Biloxi VA facility. In addition, Honolulu VA officials said reimbursement difficulties have led to delays in getting and paying bills from Tripler, which has hindered their ability to capture workload information through the billing process in a timely way.

Biloxi and Honolulu officials have taken some steps to better collect workload information. Biloxi officials reported a recent approach in which Biloxi VA staff already located at Naval Hospital Pensacola collect information about the care VA surgeons provide there; that information is later entered into VA's IT system. Officials said this new solution seems to work well, but takes time and resources, and is not as efficient as if their IT systems allowed an easier way to collect this information. In addition, some DOD providers who treat patients at the Biloxi VA facility now separately enter workload information into DOD's IT system. Biloxi DOD officials said this solution is a work in progress, but it would be preferable if the IT systems allowed them to capture workload information, as some clinical staff have said they don't have time for this extra data entry step. Honolulu officials said that while they still have difficulties capturing workload information as quickly as they would like, that their eDR IT tool improved their ability to capture workload information in a more timely way by automating aspects of the reimbursement process.

At the department level, VA officials told us that the Intra-Governmental Payment and Collection System effort related to bill payment would help VA capture information when its providers deliver care at DOD facilities, so that those providers and the VA facilities can get credit for the workload. Honolulu VA officials said this system would improve their ability to collect workload information because that information would automatically be captured when they paid bills from DOD. As of June 2012, there had been no DOD-wide efforts to deal with workload capture issues.

Dual credentialing of providers. Providers who deliver care in both VA and DOD facilities as part of collaboration efforts must be “credentialed” by both facilities. Credentialing is a process in which health care providers are systematically screened and evaluated for their qualifications and other credentials, including their licensure, education, training, and current competence. Biloxi and Honolulu joint venture officials said that the credentialing process is time-intensive and that dual credentialing creates some duplication of effort as staff members repeat many credentialing steps already completed by their collaboration partner. Honolulu VA officials added that dual credentialing also can create delays between the time new providers join their facility and when they can begin clinical work at their collaboration partner’s facility, because the extra credentialing steps must first be completed. They said that it also complicates staffing. For example, if a dually credentialed VA social worker who works at Tripler Army Medical Center is on vacation or is ill, VA cannot send a non-dually credentialed social worker to take that person’s place.

At the department level, to address concerns about dual credentialing, a Health Executive Council review resulted in a December 2010 memorandum of understanding between VA and DOD that was intended to facilitate credentialing and reduce the time and costs associated with dual credentialing. The memorandum established guidelines for how credentialing information collected and verified by one department can be shared with the other department.³⁸ Under these guidelines, VA and DOD facilities can share a range of information about providers as part of the credentialing process, such as details about providers’ education and training. However, VA and DOD facilities must still independently verify information that can expire or go out of date, such as providers’ licensure and board certification status.³⁹ Biloxi officials told us that the ability to use credentialing information collected by their collaboration partner has helped facilitate the credentialing process, but noted that there is still a fair amount of overlapping credentialing work to conduct. VA and DOD

³⁸The guidelines were based on standards and guidance from The Joint Commission, a nonprofit organization that evaluates and accredits more than 16,000 health care organizations in the United States, including VA medical centers and military treatment facilities. VA and DOD credential health care professionals in accordance with The Joint Commission’s credentialing standards.

³⁹Board certification is a process of testing and evaluation in which providers demonstrate to medical “boards” comprised of medical providers that they have expertise in a particular medical specialty, such as internal medicine, radiology, or surgery.

department-level officials told us, in their view, the departments have done all they can to streamline dual credentialing.

Overlapping computer security training. According to VA and DOD, staff involved with collaboration efforts have to complete both VA and DOD computer security training to access both departments' IT systems, which leads to some overlap in effort and loss of productivity because of the time it takes staff to complete the dual training. The Health Executive Council began work in June 2009 on a demonstration project examining how to reduce the overlapping mandatory training taken by VA and DOD staff, and selected computer security training as one of four high priority focus areas.

In August 2011, VA formally accepted three of the four DOD courses reviewed as part of this demonstration, and as a result, will grant reciprocity when DOD staff complete those courses and will not require DOD staff to take VA's corresponding training courses.⁴⁰ Although VA developed a strategy for implementing this decision, as of May 2012 the department had not made any progress in implementing the strategy, according to VA officials. They cited a number of delays and said that VA training of management staff would begin work on this effort once a separate VA computer security initiative had been fully implemented; however, they did not have an expected time frame for when implementation would occur. In contrast to VA, DOD decided not to grant reciprocity to VA staff for their VA computer security courses because, according to DOD, officials decided that VA's courses were not similar enough to DOD's to warrant reciprocity.

Accessing Medical Facilities on Military Bases

According to VA and DOD officials, the procedures DOD uses to maintain security at military base entrances can hinder access to medical facilities located on bases for veterans and those accompanying them. Base access procedures are critical to protecting DOD personnel and assets; they are established locally by military leaders at each base on the basis of factors such as that base's specific security needs and guidance from

⁴⁰In order to be granted reciprocity by VA, DOD staff must also sign the VA National Rules of Behavior regarding the appropriate use and protection of information used to support VA missions and functions, as well as meet VA's privacy training requirements. VA has decided to grant reciprocity for several DOD privacy courses, but DOD staff must take a gap course to cover VA-specific privacy statutes.

the department and the military services. The need to ensure base security may add some complexity and time for veterans and their escorts accessing care on the base, as DOD personnel perform security checks as part of their base access procedures. Such procedures may include determining whether veterans and their escorts have sufficient identification, and proof of vehicle insurance and registration; as well as inspecting the vehicles transporting the veterans. (See fig. 4.) In some cases, base personnel may require veterans to provide documentation of their health care appointment or may conduct background screening in which the veteran is vetted against government databases, such as the National Crime Information Center.⁴¹ Access procedures can change over time because of changes in local military leadership, guidance, and other factors such as security threat levels.

⁴¹The National Crime Information Center is a criminal justice information system maintained by the Federal Bureau of Investigation that contains information such as individuals' criminal history records.

Figure 4: Signage at the Entrance to the Base That Houses Tripler Army Medical Center in Honolulu, Hawaii



Source: GAO.

Officials told us these base access procedures can take time and in some cases—such as during specific episodes of heightened security—may prevent veterans from accessing care in a timely manner. Veterans who are late to health care appointments due to access difficulties might be unable to receive care and have to return for rescheduled appointments. Such missed appointments can lead to lost revenue for the military treatment facility, which will not receive reimbursement as expected, as well as inefficiencies, when staff time allotted for seeing patients goes unused. In addition, VA department-level officials told us that base access issues could dissuade some local VA officials from partnering with DOD medical facilities. Base access procedures also can lead local officials to spend time and resources developing and implementing approaches to try to facilitate veterans' access to care.

Collaboration sites have taken some actions to mitigate the impact of base access procedures on veterans and their escorts and facilitate access to care.

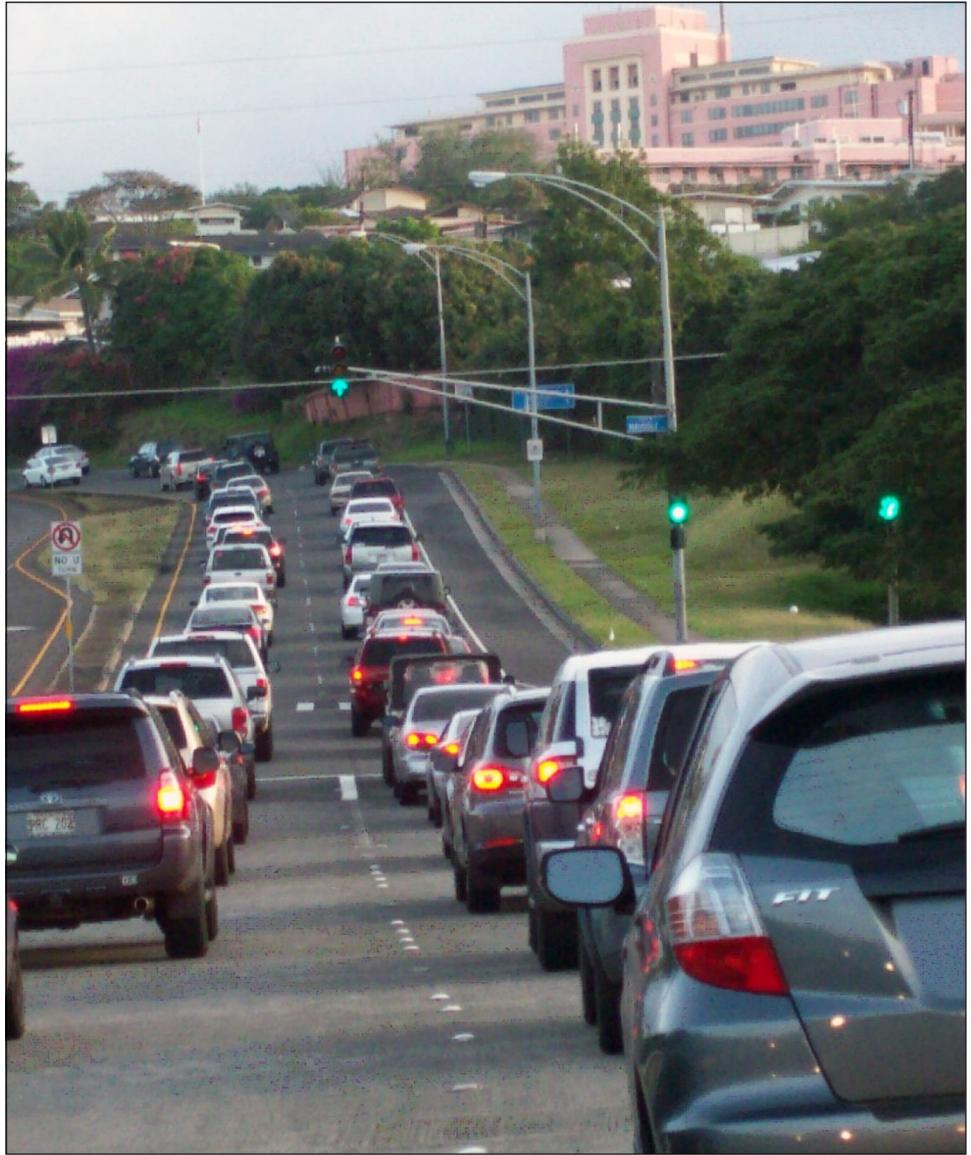
- In some locations, base access issues have factored into officials' efforts to build facilities on base with unique security arrangements. For example, VA's outpatient clinic is on the perimeter of the Navy base that houses Naval Hospital Pensacola, and is separated from the rest of the base by a security fence, which Biloxi VA and Navy officials said facilitates easy public access for both veterans and Navy personnel. Officials implemented a similar approach at Eglin Air Force Base, also in Florida, where a VA clinic on Air Force property is separated from the rest of the base by a gate that requires fingerprint verification to allow entry. Officials noted that while these approaches improve veterans' access to these VA outpatient facilities located on DOD property, difficulties can still arise when veterans seek emergency, inpatient, or other care from the military facilities located on base.
- Biloxi officials started a shuttle service to transport veterans from the VA medical center to Keesler Air Force Base to facilitate access for veterans and their escorts, including those who may not otherwise meet certain requirements for base entry; for example, veterans and their escorts avoid the need to meet vehicle registration and inspection requirements. This shuttle, however, requires added staff and resources. According to officials, as a separate effort, staff call to remind patients of the documentation needed to access the base; however, patients still sometimes fail to bring the required documentation, which can result in extra time needed to access the base and sometimes lead to missed health care appointments.
- In Honolulu, Army officials decided to accept VA's Veteran Identification Card⁴² as a valid form of identification for veterans going to Tripler Army Medical Center for health care services, which officials said improved access for veterans although not their escorts. Despite

⁴²VA's Veteran Identification Card is a card VA issues to veterans for the purpose of identifying veterans when they seek VA health care benefits and for assisting VA staff with administrative processing, though veterans are not required to have this card when they arrive for VA health care appointments. The card is for VA official business only and is issued to a veteran only after the veteran's eligibility for VA benefits has been verified; it includes a color photograph of the veteran as well as the veteran's name.

this action, it can still take a lengthy amount of time for veterans and their escorts to access the base because there is only one entry point for all individuals entering the base, including VA and DOD staff, and as a result long lines at the gate are common. (See fig. 5.) Honolulu VA officials told us that base access considerations have factored into their efforts to work with DOD to expand health care services through a new medical facility elsewhere in the community rather than by adding to the existing facilities on the base.⁴³

⁴³The VA Pacific Islands Health Care System is located on the base that houses Tripler Army Medical Center.

Figure 5: Traffic Approaching the Entrance to the Base That Houses Tripler Army Medical Center in Honolulu, Hawaii, with the Medical Center Shown in the Background



Source: GAO.

Although collaboration sites have been pursuing base access solutions at the local level—and the departments have been aware of base access issues for some time—the departments recently initiated their first joint effort to identify potential strategies for facilitating veterans' access to

care on military bases while also meeting base security needs, according to VA and DOD officials. Specifically, the Joint Chiefs of Staff initiated a new workgroup composed of VA and DOD officials to assess the military services' current base security guidance and determine potential actions that could facilitate veterans' access. As of July 2012, this workgroup had met once to discuss the issues and to begin its review of relevant guidance. One potential action the workgroup is considering is addressing how military bases treat the Veteran Identification Card as part of base access procedures. Currently, the military services have different guidance regarding the use of the card by veterans for base access purposes. VA department-level officials said that broader, more uniform acceptance of the card across the military services would be a useful step in facilitating access for veterans, but noted that it would not be a comprehensive solution, because it would not apply to people accompanying veterans to their appointments.

VA and DOD could face some difficulties identifying base access solutions that meet the security needs of military leadership, given the varied and changing security needs at the local level. However, without a sustained joint effort at the department level to explore ways to remove barriers to care across collaboration sites, veterans' ability to access medical care will vary considerably. In addition, local officials will continue to spend time and resources developing and implementing workarounds to try to appropriately balance DOD's need to maintain base security with veterans' need to access care.

In addition, given the base access difficulties that can arise, it is important for sites to consider base access issues when they are considering new or expanded collaboration. Both DOD and VA department-level officials noted that base access is a critical consideration for collaboration efforts, and VA officials added that they raise the issue with local officials who are planning new collaborations. However, officials acknowledged that current guidance from both departments about VA and DOD collaboration efforts—such as memoranda of agreement and understanding between the departments, and key department-specific handbooks and instructions—does not explicitly address base access or encourage local officials to prospectively identify potential base access issues and ways to address them.

Joint VA and DOD Planning for Construction of Medical Facilities

VA and DOD department-level officials reported that several barriers hinder their efforts to jointly plan construction of medical facilities to serve both departments' beneficiaries, and sometimes lead to missed opportunities to collaborate. For example, VA's and DOD's separate processes for reviewing proposed projects—including joint projects—are not well aligned. The processes occur on different timelines and use different criteria to rate and rank proposed projects, and in the past there has been no formal mechanism for the departments to systematically share information to identify opportunities for joint projects, according to officials.⁴⁴ As a result, a potential joint project may not move forward if it is not deemed high priority by both departments,⁴⁵ or when both departments cannot secure approval and funding for it in the same time frame. Further, local officials may do a substantial amount of planning for a project before contacting the other department about a potential collaboration, and by then it may be too late to collaborate as efficiently as possible. Officials also said that legal considerations can sometimes affect their joint construction efforts.

Efforts to collaborate at Ft. Benning in Georgia illustrate some of the difficulties VA and DOD have experienced in jointly planning for construction of new medical facilities. Although VA and DOD officials saw benefits—including the opportunity to potentially save costs and improve patient care—to building a VA clinic that would either be part of the new Army hospital currently under construction at Ft. Benning or on Army property near the new hospital, the departments' misaligned construction planning and funding processes were barriers to this effort, according to VA and DOD officials. Despite discussions within the departments about a potential joint effort at Ft. Benning, officials could not align the funding and approval processes for such an effort. Officials have also considered another option—colocating a new VA clinic with a new Army clinic elsewhere in the community, but have not been able to move forward with

⁴⁴VA's Strategic Capital Investment Planning process occurs each fiscal year, takes about 10 months to complete, and involves more than 1,000 projects, including construction projects, leases, and maintenance projects to meet the department's overall needs, not just its medical facility needs. In contrast, DOD's Capital Investment Decision Model process occurs every 18 months, takes about 16 months to complete, and involves roughly 60 to 80 projects to specifically meet DOD's medical facility needs.

⁴⁵VA department-level officials noted that proposed joint projects must compete with all other projects proposed to meet the department's overall needs, including projects that address safety issues.

that option either.⁴⁶ Local VA and DOD officials noted that the inability to build a VA clinic at the new Army hospital site or to colocate the clinics in the community likely reduced some opportunities to avoid costs and improve access to care. For example, VA officials said having a VA clinic at the new hospital site likely would have allowed VA and DOD to share the same laboratory and radiology services and could have improved access by having VA and DOD resources on one campus. VA department-level officials noted that the inability to move forward with joint construction at this location does not preclude local officials from collaborating through sharing agreements.⁴⁷ Most recently, VA has explored establishing its new clinic in another location in the community, not colocated with the Army clinic, but as of May 2012 no final decisions had been made about where VA will locate its new clinic.

As an example of how legal considerations can affect joint construction efforts, officials from VA in Biloxi and one of its DOD collaboration partners, Naval Hospital Pensacola, wanted to build a joint VA/DOD clinic on Navy property in Panama City, Florida, but due to legal considerations ultimately decided to instead build two separate clinics in close proximity. Specifically, officials said they changed their plans after learning that combining VA and Navy funds for a single joint clinic would have exceeded VA's statutory limit for minor construction projects because the total funding amount—not just VA's contribution—would count toward the statutory limit.⁴⁸ Officials said if they had reduced the project's scope to fall within VA's minor construction limit, it would not have met their needs for clinical care, so they instead opted to build two separate clinics. Officials were not certain of the cost impact of providing services in two clinics rather than one, but believed doing so would be less efficient and potentially more costly. For example, they said a single clinic would have allowed for some logistical streamlining and avoided the need to duplicate building services like electrical utilities. The departments could have

⁴⁶Among the reasons for not colocating a VA clinic near the Army clinic, VA officials told us the new Army clinic's location does not provide sufficient access to public transportation to meet VA's needs.

⁴⁷There are several sharing agreements in place between the Army and its local VA partner at this location, according to local VA and DOD officials.

⁴⁸Their plan was to use \$10 million in VA funds and \$2 million in Navy funds, but the total \$12 million funding amount would have counted against the \$10 million statutory limit for VA minor construction projects. The Navy's corresponding minor construction limit is \$2 million.

pursued this project as a major construction project rather than as a minor construction project, but would have needed to obtain congressional authorization to do so, since major construction projects generally must be specifically authorized by Congress. VA and DOD department-level officials added that potential major construction projects must compete internally for approval; as a result, the departments would not necessarily have approved this joint project to proceed as a proposed major construction project.

VA and DOD have taken several steps that have the potential to help overcome some of the departments' differences and improve joint planning for medical facility construction. For example, VA and DOD officials participate in each other's construction planning processes,⁴⁹ so they can provide insight on each department's projects under consideration and on other potential collaboration projects; officials said that doing so has helped their collaboration efforts. The departments have also worked together on legislative proposals that, in their view, could enhance their ability to collaborate on joint efforts. For example, VA, in its fiscal year 2013 congressional budget submission, stated that it would propose legislative changes that would allow VA to transfer funds to—and receive funds from—another federal agency to use for the planning, design, or construction of a shared or joint medical facility, or to lease space for such a facility; in June 2012, VA department-level officials told us they were working on VA's legislative proposal. DOD is exploring similar legislative changes. In addition, the departments are improving their information sharing to better inform their planning processes. As an initial step, VA and DOD department-level officials identified several types of data to be shared between the departments to help identify collaboration opportunities early in the construction planning process. As a result, as part of the most recent round of VA's planning process, local VA officials had access to information such as DOD population and workload information to help them identify opportunities for joint construction and leasing. Department-level DOD officials said they would share VA population and workload data with the military services during the next round of DOD's planning process as well. Officials from both

⁴⁹The participants include members of the VA/DOD Construction Planning Committee, which VA and DOD established in 2005 as a committee under the Joint Executive Council to provide a formalized structure to facilitate cooperation and collaboration in achieving an integrated approach to construction planning initiatives that are mutually beneficial to both departments.

VA and DOD Do Not Have a Fully Developed Process for Systematically Identifying New and Enhanced Collaboration Opportunities

departments said they plan to build on these initial efforts by refining their data sharing processes. For example, officials are exploring sharing additional types of data to inform their departments' construction planning processes and have identified the need to institute a more formalized process for sharing data with local officials.

VA and DOD do not have a fully developed process for systematically identifying opportunities for new or enhanced collaboration that could facilitate the departments' shared goals of improving access, quality, and costs. Instead, the identification of new or enhanced collaboration opportunities is largely left to local medical facility leadership. Although the departments do have a process for jointly identifying a select number of sites where there are opportunities for new or expanded collaboration, that process does not address all options for collaboration across both health care systems, nor is there a requirement that the sites identified by that process move forward with collaboration. Until VA and DOD fully develop a joint process to systematically identify and pursue potential collaboration opportunities, the departments may miss opportunities to improve patients' access to and quality of care, and to reduce costs, such as by addressing overlap and duplication of services that may exist between the two health care systems.

In our previous work on interagency collaboration,⁵⁰ we reported on ways for agencies to facilitate and enhance their collaboration efforts, including ways to reduce the costly government duplication and overlap that can cost taxpayers billions of dollars each year. Our prior work has found that strategic direction is required as the basis for collaboration. As such, defining roles and responsibilities and mechanisms for coordination can help agencies clarify who will lead or participate in which activities, organize their joint activities and individual efforts, and facilitate decision making. In addition, agencies can facilitate and enhance their

⁵⁰See, for example, GAO, *Interagency Collaboration: Key Issues for Congressional Oversight of National Security Strategies, Organizations, Workforce, and Information Sharing*, GAO-09-904SP (Washington, D.C.: Sept. 25, 2009) and *National Security: Key Challenges and Solutions to Strengthen Interagency Collaboration*, GAO-10-822T (Washington, D.C.: June 9, 2010).

collaboration efforts by establishing compatible ways of working together across agency boundaries.⁵¹

However, VA and DOD do not have a fully developed process and a sufficient strategic direction to work across agency boundaries to fully identify collaboration opportunities. Specifically, the departments have not fully developed and formalized a systematic process to review all possibilities for new and expanded collaboration, but instead largely leave the identification of new or enhanced collaboration opportunities to leaders at local VA and DOD medical facilities. For example, the decisions to pursue sharing agreements, JIF project funding, and joint venture status are at the discretion of local leadership. Neither departmental or joint VA and DOD guidance describe a systematic department-level process for the identification of all potential collaboration opportunities that may exist between the departments. DOD's instruction that governs health care collaboration with VA states that the leaders of DOD's military treatment facilities are to monitor emerging opportunities for collaboration and to conduct financial analyses and negotiate sharing agreements with local VA medical facilities, among other things.⁵²

Similarly, VA's handbook that defines procedures for health care collaboration with DOD medical facilities states that leadership of VA medical centers may decide to pursue collaboration options with DOD such as sharing agreements, JIF project funding, and joint venture status.⁵³ Officials from the department-level VA/DOD coordination offices said these decisions are largely left to local leaders because they do not have authority over local facilities; rather they can only offer guidance. Further, officials said local-level officials have more direct knowledge of their locations, and as such, are better positioned to assess their unique circumstances and determine what types of collaboration make the most sense.

While there are some positive reasons for involving local officials in identifying opportunities for collaboration, relying solely on local officials, rather than using a systematic process supported at the department level, can be problematic for several reasons. For example, officials from both

⁵¹[GAO-06-15](#).

⁵²DOD, *DOD and Department of Veterans Affairs Health Care Resource Sharing Program*, DOD Instruction 6010.23 (Jan. 23, 2012).

⁵³VHA, *VA-DOD Direct Sharing Agreements*, VHA Handbook 1660.04 (Oct. 2, 2008).

departments acknowledged that collaboration is dependent on local leaders' personalities and willingness to collaborate; some leaders may be greatly interested in exploring collaboration opportunities, while others may not. Moreover, given the regular changes in military treatment facility leadership, local leaders' interest and commitment to collaborating can change over time. One additional difficulty with decisions made outside of a broader systematic process is that local medical facility leadership may not have readily available access to information necessary to examine what health care services could benefit from collaboration. For example, local leaders may not know when providing certain health care services through collaboration efforts rather than by purchasing care from non-VA or non-DOD providers would be likely to result in significant cost savings. Without comprehensive information on such purchased care, officials may be hindered in their efforts to identify areas or services that could be purchased from or provided to a partner facility at a lower negotiated rate, thus reducing costs to the federal government and possibly providing additional nonfinancial benefits.⁵⁴ Some local officials we spoke with said they encountered difficulties obtaining purchased care information from their collaboration partner, and in one case encountered some resistance internally regarding sharing such information with their partner.

In an effort to facilitate more department-level direction and systemize the identification of collaboration opportunities, the departments implemented a process to identify a select number of sites where there are opportunities for new or enhanced collaboration, and designate them as Joint Market Opportunities (JMO) sites. However this process has limitations, because it does not identify all opportunities; is not formalized in guidance; and is not enforceable, as local officials still have discretion about which opportunities to pursue. Since 2009, a Health Executive Council work group—composed of VA and DOD department-level officials and representatives from the military services—has designated a few new JMO sites annually,⁵⁵ using criteria that have changed over time, but have included the proximity of VA and DOD facilities to each other, the size of

⁵⁴VA and the Air Force routinely exchange information on such purchased care through a shared data system, called DataMart. Army and Navy officials have opted not to use the DataMart system and told us that this type of information was available to local medical facility leadership through financial management offices within DOD.

⁵⁵The most recent joint strategic plan for VA and DOD collaboration includes a goal to identify two new JMO sites per year. VA and DOD Joint Executive Council, *Joint Strategic Plan Fiscal Years 2011-2013*.

local VA and DOD beneficiary populations, current working relationships of local facility leadership, current and possible collaboration initiatives, and current or planned construction or renovation. This work group visits JMO sites to meet with local officials, explore collaboration options, and make recommendations about new or enhanced sharing agreements. VA and DOD officials define JMO sites as areas that have opportunities for sharing resources and risk that should be explored. Currently, the departments have identified 15 JMO sites.⁵⁶ Several JMO sites have resulted in new or enhanced sharing agreements as an example of improved collaboration, according to VA and DOD officials. For example, the Charleston, South Carolina, area was designated as a JMO, and in subsequent years after designation, medical facility partners within that JMO jointly constructed a new facility and obtained joint venture status.

However, the JMO process is limited as it does not involve a systematic approach to reviewing and identifying all new or enhanced collaboration opportunities that exist. Given that only a few JMOs are identified each year, the departments may be missing opportunities to encourage collaboration at other locations. Further, officials from both departments stated there is no requirement that sites designated as JMOs pursue greater collaboration. The work group does not have the authority to require—or provide oversight of—implementation of their recommendations regarding collaboration; rather, it serves in an advisory and support function only. For example, Columbus, Georgia, was previously considered a JMO site because of potential joint construction between VA and the Army at Ft. Benning. An official from VA stated that the work group performed a site visit to examine options for collaboration and provide support and advice to local medical facility leadership, but VA's and DOD's construction planning processes did not align and, as we noted earlier, proved to be barriers to joint construction at this location. VA officials stated the work group has not performed follow-up work to review ongoing collaboration at this location.

⁵⁶The 15 JMO sites are the Gulf Coast area of Florida; Denver/Colorado Springs, Colorado; Bremerton/Tacoma, Washington; Central Florida area; San Antonio, Texas; Corpus Christi, Texas; San Diego, California; Phoenix, Arizona; Fayetteville, North Carolina; Oklahoma City, Oklahoma; Omaha, Nebraska; Temple/Killeen, Texas; Columbia, South Carolina; St. Louis, Missouri; and Guam.

Conclusions

Although they share a clear recognition of the potential benefit that exists when the departments collaborate to jointly provide health care services, VA and DOD may be missing additional opportunities to meet their shared goals of improving the access to, and the quality and costs of, health care, such as by reducing duplication and overlap of services. In particular, the departments have not taken sufficient actions to: develop and use performance measures to assess the effectiveness and efficiency of collaboration, overcome key barriers to collaboration, and identify new or enhanced collaboration opportunities. Specifically, the lack of comprehensive department-wide performance measures related to access, quality, and costs related to collaboration efforts may limit key decision makers' ability to adequately assess the effectiveness of those or other future health care collaborations. Similarly, while collaboration sites need some flexibility to implement local solutions that best meet their needs, given that they have different characteristics and can encounter different problems, department-level efforts to address key barriers—such as those we identified with IT systems, business and administrative processes, base access, and joint planning for construction of medical facilities—could facilitate collaboration, as well as help reduce time and resources spent by local officials developing and implementing their own solutions. For example, additional departmental guidance about base access could help ensure that local officials consider these issues early in their discussions about new or expanded collaboration. Similarly, without comprehensive department-wide solutions or assistance, collaboration sites will continue to face significant IT challenges and spend resources on local solutions. Finally, VA and DOD lack a fully developed process for systematically identifying opportunities for new and enhanced collaboration; rather they largely leave such identification to local medical facility leadership. Without more systematic, department-level approaches to collaboration in all of these areas, opportunities to meet their shared goals for collaboration may be out of the departments' reach.

Recommendations for Executive Action

To help assess progress, identify areas for improvement, and make informed decisions about health care collaborations, we recommend that the Secretaries of Veterans Affairs and Defense require collaboration sites to develop and implement a process for using performance measures to gauge their progress in achieving goals related to access, quality of care, and costs.

To facilitate the departments' current collaboration efforts, we recommend that VA and DOD systematically identify areas where department-level actions could help address significant barriers that hinder collaboration. Specifically, we recommend that the Secretaries of Veterans Affairs and Defense take the following three actions:

- expedite and communicate a plan with time frames for when iEHR solutions will be made available to joint ventures and other collaboration sites;
- take steps to resolve problems with collaboration sites' incompatible business and administrative processes, including reimbursement for services, collection of workload information, dual credentialing, and computer security training; and
- clarify, as part of the newly initiated joint efforts to address base access, departmental guidance regarding collaboration to include a discussion of base access issues that local officials should consider when discussing and planning collaboration efforts; this could include a discussion of successful approaches that current collaboration sites have adopted to facilitate base access for veterans and their escorts.

To fully identify potential opportunities to improve access to and quality of care—and reduce costs as well as duplication and overlap between the VA and DOD health care systems—the departments should further develop a systematic process for identifying and furthering collaboration opportunities, such as through sharing agreements and joint ventures. This process should review the portfolios of the departments' health care facilities; ensure information necessary to identify collaboration opportunities is available; identify both new and expanded opportunities for collaboration; and assign responsibility to ensure identified opportunities are explored and implemented if appropriate.

Agency Comments and Our Evaluation

DOD and VA each provided comments on a draft of this report. In their comments, both departments generally concurred with each of the recommendations to the Secretaries of Defense and Veterans Affairs. (DOD's comments are reprinted in app. I; VA's comments are reprinted in app. II.) In addition, both DOD and VA provided technical comments, which we have incorporated as appropriate. The departments' specific responses to each of our recommendations are as follows:

-
- To develop and implement a process for using performance measures to gauge collaboration sites' progress in achieving goals related to access, quality of care, and costs, DOD and VA stated that their 2011-2013 Joint Strategic Plan established a cost efficiency measure for joint venture sites and noted that the Health Executive Council plans to expand this cost efficiency measure and develop additional measures for other collaboration sites. VA stated that a Health Executive Council work group would develop a plan to address this issue within 6 months of the publication of this report.
 - To expedite and communicate a plan with time frames for when iEHR solutions will be made available to joint ventures and other collaboration sites, DOD and VA stated that the IPO Advisory Board has approved an incremental plan for development of iEHR capabilities that results in achieving capabilities by the end of fiscal year 2017 and that the IPO will work with a Joint Executive Council work group to ensure stakeholders are informed of this incremental schedule.
 - To take steps to resolve problems with collaboration sites' incompatible business and administrative processes, DOD and VA stated that the Health Executive Council will work to address issues related to reimbursement, workload capture, and computer security training. In addition, both departments indicated they will continue to work with The Joint Commission to address issues related to dual credentialing of health care providers.
 - To clarify departmental guidance regarding collaboration to include a discussion of base access issues that local officials should consider when discussing and planning collaboration efforts, DOD and VA stated that they will disseminate within their respective departments the outcomes of the joint effort to address base access. Specifically, DOD stated it would disseminate those outcomes to all the organizations within the Military Health System, and VA stated it would disseminate those outcomes to all VA medical facilities.
 - To further develop a systematic process for identifying and furthering collaboration opportunities, DOD and VA stated that they would continue to work together to hone their joint market selection criteria process. Both departments generally concurred with this recommendation, but stressed the importance of the role of local leaders in the development of collaboration. Specifically, they emphasized that involvement of local officials is critical since they have the best sense of their specific health care markets, which GAO

also recognizes as an important aspect of identifying and furthering collaboration.

We are sending copies of this report to the Secretary of Veterans Affairs, Secretary of Defense, and appropriate congressional committees. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact us at (202) 512-7114 or draperd@gao.gov or (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



Debra A. Draper
Director, Health Care



Brenda S. Farrell
Director, Defense Management and Capabilities

List of Addressees

The Honorable Tim Johnson
Chairman
The Honorable Mark Kirk
Ranking Member
Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
Committee on Appropriations
United States Senate

The Honorable John Culberson
Chairman
The Honorable Sanford Bishop
Ranking Member
Subcommittee on Military Construction, Veterans Affairs
and Related Agencies
Committee on Appropriations
House of Representatives

The Honorable Sam Farr
House of Representatives

Appendix I: Comments from the Department of Defense


THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

SEP 14 2012

Ms. Brenda S. Farrell
Director, Defense Capabilities and Management Team
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

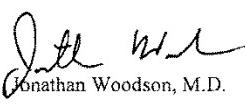
Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report GAO-12-992, "VA AND DOD HEALTH CARE: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities," dated August 20, 2012 (GAO Code 290974).

The Department appreciates the opportunity to comment on the draft report. The Department generally concurs with each of the five recommendations.

Please direct any questions to the points of contact on this matter, Mr. Kenneth E. Cox (Functional) and Mr. Gunther J. Zimmerman (Audit Liaison). Mr. Cox may be reached at (703) 681-4258, or Kenneth.Cox@tma.osd.mil. Mr. Zimmerman may be reached at (703) 681-3492, ext. 4065, or Gunther.Zimmerman@tma.osd.mil.

Sincerely,


Jonathan Woodson, M.D.

Enclosures:
1. Overall Comments

**GOVERNMENT ACCOUNTABILITY OFFICE
DRAFT REPORT – DATED AUGUST 20, 2012
(GAO-12-992)**

"VA AND DOD HEALTH CARE: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities"

DEPARTMENT OF DEFENSE COMMENTS

RECOMMENDATION 1: The GAO recommends that the Secretaries of Veterans Affairs (VA) and Defense require collaboration sites to develop and implement a process for using performance measures to gauge their progress in achieving goals related to access, quality of care, and costs.

DoD RESPONSE: DoD concurs with the recommendation. The VA/DoD Joint Strategic Plan (JSP) Fiscal Years (FY) 2011-2013 established a cost efficiency performance measure for all Joint Ventures. The Health Executive Council (HEC) plans to expand this measure, as well as develop additional measures that are applicable to additional sharing sites.

RECOMMENDATION 2: The GAO recommends that the Secretaries of Veteran Affairs and Defense expedite and communicate a plan with timeframes for when integrated electronic health record (iEHR) solutions will be made available to joint ventures and other collaboration sites.

DoD RESPONSE: DoD concurs with the recommendation. The Interagency Program Office (IPO) Advisory Board has approved an incremental capability development approach for the joint VA and DoD iEHR capabilities. It is estimated that all capabilities will be developed incrementally by the end of FY 2017. As the Full Deployment Decision is reached for each increment, capabilities will become available to the VA and DoD to execute enterprise-wide implementation. The IPO will coordinate with the VA and DoD to develop plans for the agile implementation and deployment of these capabilities as they become available, which includes availability to joint ventures and other collaboration sites. The IPO will work with the VA/DoD Joint Executive Council's Communications Work Group to ensure the communications plan for FY 2013 will include information to inform stakeholders of iEHR schedules.

RECOMMENDATION 3: The GAO recommends that the Secretaries of Veteran Affairs and Defense take steps to resolve problems with collaboration sites' incompatible business and administrative processes, including reimbursement for services, collection of workload information, dual credentialing, and computer security training.

DoD RESPONSE: DoD concurs with the recommendation. The HEC will continue its work to resolve the issues GAO cites regarding dual credentialing with The Joint Commission. The HEC will also continue its work to resolve issues related to computer security training through the Continuing Education and Training Working Group in association with all cognizant agencies. Lastly, the HEC will also add to its agenda the issues GAO cites regarding reimbursement and workload information capture.

RECOMMENDATION 4: The GAO recommends that the Secretaries of Veteran Affairs and Defense clarify, as part of the newly initiated joint efforts to address base access, departmental guidance regarding collaboration to include a discussion of base access issues local officials should consider when discussing and planning collaboration efforts. This could include a discussion of successful approaches that current collaboration sites have adopted to facilitate base access for veterans and their escorts.

DoD RESPONSE: DoD concurs with the recommendation and will ensure that the outcomes of the joint effort to address base access is widely disseminated to all organizational elements within the Military Health System.

RECOMMENDATION 5: The GAO recommends that the Secretaries of Veteran Affairs and Defense further develop a systemic process for identifying and furthering collaboration opportunities, such as through sharing agreements and joint ventures. This process should review the portfolios of the departments' health care facilities, ensure information necessary to identify collaboration opportunities is available; identify both new and expanded opportunities are explored and implemented, if appropriate.

DoD RESPONSE: DoD generally concurs with the recommendation with the following comments. As GAO cites in the draft report, DoD has worked closely with the Military Departments and the Department of Veterans Affairs to develop a systematic and measured approach to furthering collaborative initiatives through the JSP. The Department's approach has been to require local Military Treatment Facility (MTF) Commanders to intentionally consider VA in all aspects of their annual planning efforts. But, we will continue to work with VA to hone our joint market selection criteria process along with developing a measuring evaluation process to help determine level of collaboration success, a process that is done in conjunction with the local site.

The Department views this partnership between headquarters and the local sites as critical, because the Department has always interpreted the language at 38 United States Code 8111, which specifically identifies and empowers "heads of medical facilities..." as intending resource sharing to be largely a grassroots endeavor. The Department is committed to continuing to take full advantage of the authorizing legislation, and believes that Congress appropriately targeted this legislative authority to the local level because it is these local officials who have the best knowledge of their local health care markets. Accordingly, the Joint Guidelines signed by the Deputy Secretaries of Defense and Veterans Affairs required by the same statute, as well as the Department of Defense Instruction on Health Care Resource Sharing Program (DoDI 6010.25) clearly establish headquarters oversight and monitoring, but equally emphasizes the "bottom-up" nature of the collaboration program.

Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

September 17, 2012

Ms. Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA AND DOD HEALTH CARE: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities**" (GAO-12-992) and generally agrees with GAO's conclusions and concurs with four recommendations and concurs in principle with one of GAO's five recommendations to the Department.

The enclosure specifically addresses GAO's five recommendations and provides technical comments. VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "John R. Gingrich".

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**"VA AND DOD HEALTH CARE: Department-Level Actions Needed to Assess
Collaboration Performance, Address Barriers, and Identify Opportunities"**
(GAO-12-992)

Recommendation 1: To help assess progress, identify areas for improvement, and make informed decisions about health care collaborations, we recommend that the Secretaries of Veterans Affairs and Defense require collaboration sites to develop and implement a process for using performance measures to gauge their progress in achieving goals related to access, quality of care, and costs.

VA Response: Concur. The Fiscal Year (FY) 2011- 2013 Department of Veterans Affairs (VA)/Department of Defense (DoD) Joint Strategic Plan (JSP) set a measure for VA/DoD Joint Ventures to demonstrate cost efficiencies. The VA/DoD Health Executive Council (HEC) plans to expand this measure to other sites and develop additional measures for VA/DoD sharing sites. The HEC Joint Venture/Resource Sharing Work Group will develop a plan for HEC consideration of this issue in 6 months from the publication of the report.

To facilitate the departments' current collaboration efforts, we recommend that the VA and DOD systematically identify areas where department-level actions could help address significant barriers that hinder collaboration. Specifically, we recommend that the Secretaries of Veterans Affairs and Defense take the following three actions:

Recommendation 2: Expedite and communicate a plan with timeframes for when iEHR solutions will be made available to joint ventures and other collaboration sites;

VA Response: Concur. The Interagency Program Office (IPO) Advisory Board has approved an incremental capability development approach for the joint VA and DoD integrated electronic health record (iEHR) capabilities. It is estimated that all capabilities will be developed incrementally by the end of FY 2017. As the Full Deployment Decision (FDD) is reached for each increment, capabilities will become available to VA and DoD to execute enterprise-wide implementation. The IPO will coordinate with VA and DoD to develop plans for the agile implementation and deployment of these capabilities as they become available, which includes availability to joint ventures and other collaboration sites. The IPO will work with the VA/DoD Joint Executive Council's Communications Work Group to ensure the communications plan will include information to inform stakeholders of iEHR schedules.

Recommendation 3: Take steps to resolve problems with collaboration sites' incompatible business and administrative processes, including reimbursement for services, collection of workload information, dual credentialing, and computer security training; and

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**"VA AND DOD HEALTH CARE: Department-Level Actions Needed to Assess
Collaboration Performance, Address Barriers, and Identify Opportunities"**
(GAO-12-992)

VA Response: Concur. The HEC, and its associated work groups, will continue its work to resolve the incompatible business and administrative processes including reimbursement for services, collection of workload information, and computer security training.

VA representatives met with the HEC Financial Management Work Group Co-chairs on September 10, 2012, to discuss updates to the Financial Management Work Group Charter to emphasize the administrative and business processes as identified by the GAO review. It is expected that a revised charter will be coordinated between VA and DoD by July 2013.

With regard to the recommendation for dual credentialing, VA will continue its work with the accrediting agency (The Joint Commission) as well as all stakeholders to streamline the credentialing process at joint and co-located facilities. Also, the HEC Co-chairs are establishing a task force to explore the feasibility of a joint credentialing system. The task force expects to provide a preliminary report to the HEC by March 2013.

Recommendation 4: Clarify, as part of the newly initiated joint efforts to address base access, departmental guidance regarding collaboration to include a discussion of base access issues local officials should consider when discussing and planning collaboration efforts. This could include a discussion of successful approaches that current collaboration sites have adopted to facilitate base access for veterans and their escorts.

VA Response: Concur. VA officials including representatives from VA Central Office, the Office of the Deputy Under Secretary for Health for Operations and Management, and local officials at the Veterans Integrated Service Network (VISN) and facility levels will continue to work with appropriate DoD officials as well as local DoD facilities to overcome base access issues for Veterans. VA will ensure that the outcomes of the joint effort are widely disseminated to all VA medical facilities.

Recommendation 5: To fully identify potential opportunities to improve access to and quality of care – and reduce costs as well as duplication and overlap between the VA and DoD health care systems – the departments should further develop a systematic process for identifying and furthering collaboration opportunities, such as through sharing agreements and joint ventures. This process should review the portfolios of the departments' health care facilities, ensure information necessary to identify collaboration opportunities is available; identify both new and expanded opportunities for collaboration; and assign responsibility to ensure identified opportunities are explored and implemented if appropriate.

**Appendix II: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**"VA AND DOD HEALTH CARE: Department-Level Actions Needed to Assess
Collaboration Performance, Address Barriers, and Identify Opportunities"**
(GAO-12-992)

VA Response: Concur in principle. VA continues to seek new and expanded opportunities for collaboration. For example, VA has worked closely with DoD to develop a systematic and measured approach to expanding collaborative initiatives through the JSP. The JSP provides for an annual assessment of VA and DoD health care facilities, using pre-determined criteria, to identify potential opportunities for new collaboration. Also, monthly meetings are held between the Director, DoD Medical Sharing Office, and VISN Sharing Coordinators to discuss opportunities for sharing services based on VA and DoD purchased care data, guidance for initiating sharing agreements, and Joint Incentive Fund projects.

VISN and Medical Facility Directors use the Veterans Health Administration's (VHA) VHA Directive 2010-040, Health Care Resources Sharing, with DoD, to identify, plan for, and implement sharing activities with policy guidance, facilitation, and assistance from the VA Department level. VA will continue to work with DoD to hone and improve our joint market selection criteria process.

VA interprets the language in Title 38, United States Code, section 8111, which specifically identifies and empowers "heads of medical facilities," as intending resource sharing to be largely a grassroots endeavor. VA believes that Congress appropriately targeted this legislative authority to the local level because it is these local government officials who have the best knowledge of their local health care markets. Accordingly, the Memorandum of Understanding between VA and the DoD Health Care Resources Guidelines, signed by the Deputy Secretaries of Defense and VA and required by the same statute, clearly establish corporate oversight and monitoring, but equally emphasize the "bottom-up" nature of the collaboration program.

Appendix III: GAO Contacts and Staff Acknowledgments

GAO Contacts

Debra A. Draper, (202) 512-7114 or draperd@gao.gov, and
Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov

Staff Acknowledgments

In addition to the contacts named above, Lori Atkinson, Assistant Director; Marcia A. Mann, Assistant Director; Robin S. Burke; Jill K. Center; Suzanne M. Perkins; and Leigh Ann E. Sennette made key contributions to this report. Lisa A. Motley and Michael Willems provided legal support, and Jennie F. Apter assisted in report development.

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